P028-e

Rehabilitation treatment of the thoracic outlet syndrome (TOS)

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Objective Identify the different modalities of rehabilitative care of TOS through a review of the literature and our experience in the unity of physical medicine and rehabilitation (PMR) in Mahdia.
Material and methods A retrospective study during the last three years including patients with TOS addressed to the unity of PMR of Mahdia. The evaluation was clinical (visual analogue scale pain VAS, examination of the cervical spine and dynamic tensioning test of the brachial plexus), functional (Orset stage) and radiological. A program of 15 rehabilitation sessions has been achieved.
Results 14 patients (13 women and one man) with a mean age 39.92 years were collected. Symptoms were primarily neurological with paresthesia in 71.42%, a C8-D1 cervical radiculopathy in 21.42% of cases, heaviness in the upper limbs in 14.28% of cases. Venous symptoms and hand edema were found in 28.57% of cases. Raynaud's syndrome was found in only one case (7.14%). The Wright manoeuvre was positive in 35.71% of cases and Roos test was positive in 78.57% of cases. The dynamic test revealed a tensioning of the brachial plexus by the median nerve in 57.14% of cases and by the ulnar nerve in 42.85% of cases. A double crush syndrome was found in 21.42% of cases. Initial average pain VAS was 73 mm. Radiological assessment revealed a cervical rib in 14.28% of cases and mega-apophysis C7 in 21.42% of cases. After rehabilitation, there was an improvement in pain (mean VAS 21 mm) and short-term results were good in 78.57% of cases.
Discussion and conclusion TOS rehabilitation is often efficient; it corrects the muscle imbalance reducing the diameter of the thoracic outlet and decompensating his asymptomatic constitutional smallness. If there are no serious vascular or neurological complications, it remains the first-line treatment.
Keywords Thoracic outlet syndrome; Rehabilitation
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P029-e

Case report of a double spontaneous rupture: Quadriceps tendon and contralateral Achilles tendon

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Introduction Uni- or bilateral quadriceps tendon ruptures are rare (1.37/100,000 person-years), those of the Achilles tendon are more common (21.5/100,000 person-years). To our knowledge, concomitant combination of these two ruptures has not been reported in the literature. This case reports a spontaneous rupture of quadriceps tendon and of Achilles contralateral tendon.
Observation 54 years, athletic patient without comorbidity, known for a ruptured left quadriceps tendon two years ago. During a ski descent, he presents a complete spontaneous rupture of the right quadriceps tendon and partial rupture of the left Achilles tendon, both repaired surgically. A stationary environment rehabilitation allowed a full recovery.
Discussion Risk factors known in the literature for these tendon ruptures [1,2] (age, certain medications, anabolic steroids, certain systemic diseases, obesity, corticosteroid injections, static disorders in the knee or ankle, previous surgery) have not been found for this patient. The usually described triggers mechanisms could be found in this case (eccentric quadriceps contraction, sudden contraction of the sural triceps), occurring on tendons potentially weakened by repetitive microtrauma caused by intensive sport. However, this double spontaneous rupture and the previous rupture of the contralateral quadriceps tendon 2 years ago are suggestive of tendon abnormalities. In case of repetition, an histological analysis of the ruptured tendon could be achieved to assess the organization and structure of collagen fibers, tenocytes and microvascularization [3]. The search for a COL5A1 polymorphism also seems interesting because it has been associated with spontaneous tendon ruptures [3,4].
Keywords Rupture; Tendon; Quadriceps; Achilles
Disclosure of interest The authors have not supplied their declaration of conflict of interest.
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P030-e

Hip septic arthritis diagnosed during rehabilitation of a trans-tibial amputation due to a diabetic foot ulcer: a case report

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Introduction A major part of lower limb amputations concerns patients with diabetes, and is related to the appearance of a diabetic foot ulcer, that can cause serious complications if it becomes septic.
Observations A 64-year-old woman with diabetes mellitus, socially isolated, is hospitalized, being in a hyperosmolar coma; her diabetes was decompensated by a toxic shock due to a necrotic diabetic foot ulcer, requiring right trans-tibial amputation. Then she was admitted to a rehabilitation unit, where she was suffering from increasing left hip pains (strongly limiting her capacity to walk), in a clinical and biological inflammatory context, that led us to make a MRI. A liquid collection into left ilio-psoas muscle associated to a rapidly destructive left hip arthritis were diagnosed. PET-scan was in favour of a septic arthritis. Surgery enabled to make biological samples (finding a *Bacteroides fragilis* and meticillin-resistant *Staphylococcus aureus* infection), and a to implant a hip spacer, pending a hip prosthetic replacement.
Discussion The most likely etiologic diagnosis–although not certain–seems to be an infected psoas hematoma (the first hip pains she notified were accompanied by a slight hemolysis), that caused septic hip arthritis by spreading by contiguity. Among anaerobic hip infections, Gram-positive cocci are most frequently found in patients having been treated by surgery (such as arthroplasties), whereas Gram-negative bacterias are more related to debilitated patients who had not had any hip surgical treatment [1].
Conclusion In case of diabetic foot ulcer infection, we should always think about the risk of a systemic infectious complications. Atypical left hip pains can be the only symptom of an infected psoas hematoma in debilitated patients as described in this observation.